MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

3315 West Truman Blvd.
P.O. Box 58
Jefferson City, MO 65102-0058

REQUEST FOR AWARD ON UNDISPUTED FACTS IN REGARD TO APPLICATION FOR DIRECT PAYMENT

_____, Health Care Provider,

vs.

_____, Employer,

and

_____, Insurer

Medical Fee Dispute No: ____-_____

Injury No.: ____-_____

Employee (Patient): _____

Date of Accident/
Occupational Disease: _____

REQUEST FOR AWARD ON UNDISPUTED FACTS

Employer hereby requests that an Administrative Law Judge of the Division of Workers' Compensation issue an award denying the APPLICATION FOR DIRECT PAYMENT filed herein by _____
(name of health care provider)
on the ground that the health care services for which direct payment is being sought were not authorized by Employer or its Insurer. In support of this request, Employer states that there is no genuine issue of fact necessitating an evidentiary hearing in regard to the APPLICATION FOR DIRECT PAYMENT, and that the following facts are undisputed *(attach additional sheets, if necessary)*:

In support of the undisputed facts listed above, Employer attaches the following exhibits *(attach additional sheets, if necessary)*: Please identify each exhibit by letter "A," "B," etc. and by general description of the document.

_____ Employer/Insurer Signature & Date

_____ Employer Address & Telephone No.

_____ Employer/Insurer Attorney's Signature & Date

_____ Attorney's Address & Telephone No.

CERTIFICATE OF SERVICE

I, the undersigned, certify that, a copy of this Request for Award on Undisputed Facts is true and accurate, and I further certify that a copy of this Request for Award on Undisputed Facts has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP